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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: ALEXANDER LEE NEIL, JR. 18795 Caminita Cantilena #101 San Diego, CA 92128-6156 Registered Nurse License No. 446710 Respondent.	Case No. 2008-135 **DEFAULT DECISION AND ORDER** [Gov. Code, §11520]

FINDINGS OF FACT

1. On or about October 16, 2007, Complainant Ruth Ann Terry, M.P.H., R.N., in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs, filed Accusation No. 2008-135 Against Alexander Lee Neil, Jr. (Respondent) before the Board of Registered Nursing.

2. On or about September 30, 1989, the Board of Registered Nursing (Board) issued Registered Nurse License No. 446710 to Respondent. The Registered Nurse License expired on June 30, 2005, and has not been renewed.

3. On or about November 1, 2007, Mona Sebastian, an employee of the Department of Justice, served by Certified Mail and First Class Mail a copy of the Accusation No. 2008-135, Request for Discovery, Statement to Respondent, Notice of Defense, Government

Code Sections 11507.5, 11507.6, and 11507.7, and Disciplinary Guidelines to Respondent's address of record with the Board, which was and is 18795 Caminita Cantilena #101 San Diego, CA 92128-6156. A copy of the Accusation, the related documents, and Declaration of Service are attached as exhibit A, and are incorporated herein by reference.

4. Service of the Accusation was effective as a matter of law under the provisions of Government Code section 11505, subdivision (c).

5. On or about November 8, 2007, the aforementioned documents which were served by First Class Mail were returned by the U.S. Postal Service marked "Attempted not known." A copy of the envelope returned by the post office is attached as exhibit B, and is incorporated herein by reference.

6. The copy of the documents that were served by Certified Mail were not returned to this Office.

7. On or about November 15, 2007, Mona Sebastian, an employee of the Department of Justice, again served by Certified Mail and First Class Mail a copy of the Accusation No. 2008-135, Request for Discovery, Statement to Respondent, Notice of Defense, Government Code Sections 11507.5, 11507.6, and 11507.7, and Disciplinary Guidelines to Respondent's address of record with the Board, which was and is 18795 Caminita Cantilena #101 San Diego, CA 92128-6156. A copy of that Proof of Service is attached as exhibit C and is incorporated herein by reference.

8. Service of the Accusation was effective as a matter of law under the provisions of Government Code section 11505, subdivision (c).

9. On or about November 28 2007, the aforementioned documents which were served by Certified Mail were returned by the U.S. Postal Service marked "Attempted not known." A copy of the envelope returned by the post office is attached as exhibit D, and is incorporated herein by reference.

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10. On or about November 28, 2007, the aforementioned documents which were served by First Class Mail were returned by the U.S. Postal Service marked "Attempted not known." A copy of the envelope returned by the post office is attached as exhibit E, and is incorporated herein by reference.

11. Business and Professions Code section 118 states, in pertinent part:

"(b) The suspension, expiration, or forfeiture by operation of law of a license issued by a board in the department, or its suspension, forfeiture, or cancellation by order of the board or by order of a court of law, or its surrender without the written consent of the board, shall not, during any period in which it may be renewed, restored, reissued, or reinstated, deprive the board of its authority to institute or continue a disciplinary proceeding against the licensee upon any ground provided by law or to enter an order suspending or revoking the license or otherwise taking disciplinary action against the license on any such ground."

12. Government Code section 11506 states, in pertinent part:

"(c) The respondent shall be entitled to a hearing on the merits if the respondent files a notice of defense, and the notice shall be deemed a specific denial of all parts of the accusation not expressly admitted. Failure to file a notice of defense shall constitute a waiver of respondent's right to a hearing, but the agency in its discretion may nevertheless grant a hearing."

13. Respondent failed to file a Notice of Defense within 15 days after service upon him of the Accusation, and therefore waived his right to a hearing on the merits of Accusation No. 2008-135.

14. California Government Code section 11520 states, in pertinent part:

"(a) If the respondent either fails to file a notice of defense or to appear at the hearing, the agency may take action based upon the respondent's express admissions or upon other evidence and affidavits may be used as evidence without any notice to respondent."

15. The total costs for investigation and enforcement are $13,024.00 as of November 30, 2007. Of this total, $4,108.00 are the Attorney General's costs for enforcement (Exhibit F: Certification of Costs - Declaration of Diane de Kervor) and $8,916.00 are the Board's costs for investigation of this case.

16. Pursuant to its authority under Government Code section 11520, the Board finds Respondent is in default. The Board will take action without further hearing and, based on Respondent's express admissions by way of default and the evidence before it, contained in exhibits A, B, C, D, E, and F finds that the allegations in Accusation No. 2008-135 are true.

DETERMINATION OF ISSUES

1. Based on the foregoing findings of fact, Respondent Alexander Lee Neil, Jr. has subjected his Registered Nurse License No. 446710 to discipline.

2. A copy of the Accusation and the related documents and Declaration of Service are attached.

3. The agency has jurisdiction to adjudicate this case by default.

4. The Board of Registered Nursing is authorized to revoke Respondent's Registered Nurse License based upon the following violations alleged in the Accusation:

a. Respondent's license is subject to discipline for unprofessional conduct under Code section 2762, subdivision (e) for false, grossly incorrect, or grossly inconsistent record entries for five patients on multiple occasions.

b. Respondent's license is subject to discipline for unprofessional conduct under Code section 2761, subdivision (a)(1) for several acts of gross negligence.

c. Respondent's license is subject to discipline for unprofessional conduct under Code section 2761, subdivision (a)(1) for several acts of incompetence.

d. Respondent's license is subject to discipline for several acts of unprofessional conduct under Code section 2761, subdivision (a).

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ORDER

IT IS SO ORDERED that Registered Nurse License No. 446710, heretofore issued to Respondent Alexander Lee Neil, Jr., is revoked.

Pursuant to Government Code section 11520, subdivision (c), Respondent may serve a written motion requesting that the Decision be vacated and stating the grounds relied on within seven (7) days after service of the Decision on Respondent. The agency in its discretion may vacate the Decision and grant a hearing on a showing of good cause, as defined in the statute.

This Decision shall become effective on March 19, 2008.

It is so ORDERED February 19, 2008

LaTrancine M Tate

FOR THE BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS

80184563.wpd
DOJ docket number:SD2006800286

Attachments:

Exhibit A: Accusation No.2008-135, Related Documents, and Declaration of Service
Exhibit B: Copy of Envelope Returned by Post Office
Exhibit C: Proof of Service
Exhibit D: Copy of Envelope Returned by Post Office
Exhibit E: Copy of Envelope Returned by Post Office
Exhibit F: Certification of Costs: Declaration of Diane de Kervor

Exhibit A

Accusation No. 2008-135,
Related Documents and Declaration of Service

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Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **ALEXANDER LEE NEIL JR.** 18795 Caminita Cantilena, #101 San Diego, CA 92128-6156 Registered Nurse License No. 446710, Respondent.	Case No. 2008-135 **ACCUSATION**

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. ("Complainant") brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about September 30, 1989, the Board of Registered Nursing ("Board") issued Registered Nurse License Number 446710 to Alexander Lee Neil Jr. ("Respondent"). The license expired on June 30, 2005, and has not been renewed.

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JURISDICTION AND STATUTORY PROVISIONS

3. Section 2750 of the Business and Professions Code ("Code") provides:

"Every certificate holder or licensee, including licensees holding temporary licenses, or licensees holding licenses placed in an inactive status, may be disciplined as provided in this article [Article 3 of the Nursing Practice Act (Bus. & Prof Code, § 2700 et seq.)]. As used in this article, 'license' includes certificate, registration, or any other authorization to engage in practice regulated by this chapter. The proceedings under this article shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code [the Administrative Procedure Act], and the board shall have all the powers granted therein."

4. Code section 2761, subdivision (a)(1), provides:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions."

5. Code section 2762 provides, in pertinent part:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

". . . .

"(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

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6. Code section 2764 provides:

"The lapsing or suspension of a license by operation of law or by order or decision of the board or a court of law, or the voluntary surrender of a license by a licentiate shall not deprive the board of jurisdiction to proceed with any investigation of or action or disciplinary proceeding against such license, or to render a decision suspending or revoking such license."

7. Code section 4022 provides:

"'Dangerous drug' or 'dangerous device' means any drug or device unsafe for self-use in humans or animals, and includes the following:

"(a) Any drug that bears the legend: 'Caution: federal law prohibits dispensing without prescription,' 'Rx only,' or words of similar import.

"(b) Any device that bears the statement: 'Caution: federal law restricts this device to sale by or on the order of a _____,' 'Rx only,' or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device.

"(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006."

8. Code section 125.3 provides that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

REGULATORY PROVISIONS

9. California Code of Regulations, title 16, section 1442, provides:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

10. California Code of Regulations, title 16, section 1443, provides:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

11. California Code of Regulations, title 16, section 1443.5, provides:

"A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

"(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

"(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

"(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

"(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

"(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

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"(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided."

DRUGS

12. "Ativan" is a brand of lorazepam, and is a Schedule IV controlled substance as designated by Health and Safety Code section 11057, subdivision (d)(13), and a dangerous drug within the meaning of Code section 4022.

13. "Demerol" is a brand of meperidine hydrochloride, a derivative of pethidine, and is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (c)(17), and a dangerous drug within the meaning of Code section 4022.

14. "Morphine" is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(M), and a dangerous drug within the meaning of Code section 4022.

15. "Oxycodone" is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(N), and a dangerous drug within the meaning of Code section 4022.

16. "Vicodin" is a compound consisting of acetaminophen per tablet and hydrocodone bitartrate, also known as dihydrocodeinone, and is a Schedule III controlled substance as designated by Health and Safety Code section 11056, subdivision (e)(4), and a dangerous drug within the meaning of Code section 4022.

Background

17. Respondent was employed in the Surgical Intensive Care/Trauma Unit of the University of California, San Diego Medical Center (UCSDMC), located in San Diego, California, from on or about April 26, 2002, until on or about April 11, 2003.

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18. While on duty on March 22, 2003, it was discovered that Respondent left an assigned patient unattended and perilously positioned in bed for an extended period of time. The next day, on March 23, 2002, Respondent failed to respond to a patient's calls for emergency assistance. Responding nurses discovered the patient disconnected from a ventilator in a hypotensive, bradycardic, de-oxygenated condition. Respondent was later discovered asleep in an adjacent room.

19. On March 25, 2003, during the evening shift, Respondent was discovered sleeping in the room of one of his assigned patients. Upon awakening, he was lethargic, his speech was slurred, and he had difficulty with his fine motor skills and keeping his eyes open. Respondent was also observed being repeatedly unable to change a patient's IV bag, a task which would normally take ten or fifteen seconds to complete, and he used an industrial cleaner product to clean a patient (a product not intended for use on humans) instead of soap. Respondent also failed to make entries in the medical records of two of his assigned patients, and he failed to make an initial assessment entry for one of those patients.

20. A review by UCSDMC of Pyxis[1] activity generated from the period on or about March 25, 2003, through March 26, 2003, revealed that Respondent had obtained doses of controlled substances for patient administration, but had later failed to document the administration of those substance and/or to otherwise properly account for the disposition of those substances.

21. As a result of the above conduct, Respondent was terminated from his position at UCSDMC.

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1. Pyxis is a brand name for an automated medication dispensing and supply system manufactured by Cardinal Health Company. A PIN access code is used to access controlled substances from the system which automatically logs all transactions involving the removal of controlled substances, identifying the name of the person accessing the system, the name of the patient for whom the substances have been ordered, and the date, time, and dosage being obtained.

FIRST CAUSE FOR DISCIPLINE

(False, Grossly Incorrect, or Grossly Inconsistent Record Entries for Five Patients on Multiple Occasions)

22. Respondent's license is subject to discipline for unprofessional conduct under Code section 2762, subdivision (e), in that while employed at UCSDMC, Respondent made false, grossly incorrect, or grossly inconsistent entries in hospital, patient, or other records pertaining to controlled substances, as follows:

a. **Patient "I."**

1. On or about February 6, 2003, at approximately 0455 hours, Respondent obtained a 100mgs/4ml dose of Morphine for administration to Patient "I." Thereafter, Respondent failed to document and record the administration of that controlled substance on the patient's medication administration record, or to otherwise properly account for the disposition of the Morphine.

2. On or about February 24, 2003, at approximately 0553 hours, Respondent obtained a 100mg/4ml dose of Morphine for administration to Patient "I." Thereafter, Respondent failed to document and record the administration of that controlled substance on the patient's medication administration record, or to otherwise properly account for the disposition of the Morphine.

3. On or about February 24, 2003, at approximately 2055 hours, Respondent obtained a 100mg/4ml dose of Morphine for administration to Patient "I." Thereafter, Respondent failed to document and record the administration of that controlled substance on the patient's medication administration record, or to otherwise properly account for the disposition of the Morphine.

4. On or about February 25, 2003, at approximately 0551 hours, Respondent obtained a 100mgs/4mls dose of Morphine for administration to Patient "I." Thereafter, Respondent failed to document and record the administration of that controlled substance on the patient's medication administration record, or to otherwise properly account for the disposition of the Morphine.

b. **Patient "II."**

1. On or about March 10, 2003, at approximately 2006 hours, Respondent obtained a 5mg dose of Oxycodone for administration to Patient "II." Thereafter, Respondent inconsistently recorded that the Oxycodone had been administered to the patient at 2100 hours. The entry was inconsistent in that it recorded that the Oxycodone was administered approximately one hour after it had been obtained.

2. On or about March 11, 2003, at approximately 0612 hours, Respondent obtained a 5mg dose of Oxycodone for administration to Patient "II." Thereafter, Respondent inconsistently recorded that the Oxycodone had been administered to the patient at 0400 hours.

3. On or about March 11, 2003, at approximately 1937 hours, Respondent obtained a 10mg dose of Morphine for administration to Patient "II." Thereafter, Respondent failed to document and record the administration of that substance on the patient's medication administration record, or to otherwise properly account for the disposition of the Morphine.

4. On or about March 11, 2003, at approximately 2048 hours, Respondent obtained a 5mg dose of Oxycodone for administration to Patient "II." Thereafter, Respondent inconsistently recorded that the Oxycodone had been administered to the patient at 2200 hours.

5. On or about March 12, 2003, at approximately 0017 hours, Respondent obtained a 75mg dose of Demerol for administration to Patient "II." Thereafter, Respondent inconsistently recorded that the Demerol had been administered to the patient at 0100 hours.

6. On or about March 12, 2003, Respondent inconsistently recorded in Patient "II's" medication administration record that a 30mg dose of Demerol had been administered to the patient at approximately 0400 hours. That entry was inconsistent in that Respondent had not documented that a 30mg dose of Demerol had been obtained for administration to Patient "II."

c. **Patient "III."** On or about March 17, 2003, at approximately 1932 hours, Respondent obtained a 8mg dose of Morphine for administration to Patient "III." Thereafter, Respondent failed to document and record the administration of that substance on the patient's medication administration record, or to otherwise properly account for the disposition of the Morphine.

d. **Patient "IV."**

1. On or about March 13, 2003, at approximately 0338 hours, Respondent obtained two tablets of Vicodin for administration to Patient "IV." Thereafter, Respondent inconsistently recorded that the Vicodin had been administered to the patient at 2100 hours.

2. On March 13, 2003, at approximately 0451 hours, Respondent obtained two tablets of Vicodin for administration to Patient "IV." Thereafter, Respondent inconsistently recorded that the Vicodin had been administered to the patient at 0100 hours.

e. **Patient "M. A."** Between 0532 hours, March 25, 2003, and 0646 hours, March 26, 2003, Respondent obtained a total of 44mgs of Morphine and 8mgs of Ativan for administration to Patient "M. A." Respondent charted that 4mg of Morphine had been administered to Patient "M. A." at 0800 hours. Thereafter, Respondent failed to document and record the administration of 40mgs of Morphine and 8mgs of Ativan on the patient's medication administration record, or to otherwise properly account for the disposition of 40mgs of Morphine and 8mg of Ativan.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence)

23. Respondent's license is subject to discipline for unprofessional conduct under Code section 2761, subdivision (a)(1), in that while employed at UCSDMC, Respondent committed acts of gross negligence, as forth above in paragraphs 20 and 22, and as follows:

a. On or about March 22, 2003, and on or about March 25, 2003, Respondent failed to provide adequate, timely, and appropriate patient care for his assigned patients, as more fully set forth above in paragraphs 17 through 19, above.

THIRD CAUSE FOR DISCIPLINE

(Incompetence)

24. Respondent's license is subject to discipline for unprofessional conduct under Code section 2761, subdivision (a)(1), in that while employed at UCSDMC, Respondent committed acts of incompetence, as set forth under paragraphs 17 through 22 above.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

25. Respondent's license is subject to discipline for unprofessional conduct under Code section 2761, subdivision (a), as set forth under paragraph 17 through 22 above.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing the Board issue a decision:

1. Revoking or suspending Registered Nurse License Number 446710, issued to Alexander Lee Neil Jr.;

2. Ordering Alexander Lee Neil Jr. to pay the reasonable costs incurred by the Board in the investigation and enforcement of this case pursuant to Code section 125.3; and,

3. Taking such other and further action as deemed necessary and proper.

DATED: 10/16/07

Christ Hochberg for
RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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